

Registration District No. **791**

Primary Registration District No. **1003**

Registrar's No.

1. PLACE OF DEATH:

(a) County: _____
(b) City or town: **St. Louis, Missouri**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **St. Louis City Hospital #1**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **6 Days**
(Specify whether years, months or days)

FILED DEC 11 1940

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County _____
(c) City or town **St. Louis** **17**
(If outside city or town limits, write "RURAL")
(d) Street No. **4221 Botanical Ave.**
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME **Elizabeth Raymond**

3. (b) If veteran, name war _____ 3. (c) Social Security No. **none**

4. Sex **Female** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **V**
6. (b) Name of husband or wife **William J. Raymond** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **March 17 1858**
(Month) (Day) (Year)

8. AGE: Years **82** Months **7** Days **14**
If less than one day hr. _____ min. _____

9. Birthplace **St. Louis Mo, 0**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business _____

12. Name **Joseph Schaff**

13. Birthplace **Germany**
(City, town, or county) (State or foreign country)

14. Maiden name **Elizabeth Louy**
(City, town, or county) (State or foreign country)

15. Birthplace **Germany**
(City, town, or county) (State or foreign country)

16. (a) Informant **Rev. Father Guilbert**

(b) Address **City Hospital #1**

17. (a) **Burial** (b) Date thereof **11-2-40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Resurrection Cemetery**

18. (a) Signature of funeral director **Chas. A. Bull**

(b) Address **4457 Washington Bl.**

19. (a) **NOV 1 1940** (b) _____
(Date received local registrar) (Date received from _____)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **October** day **31**, year **1940** hour **12:10** minute **A.** M.

21. I hereby certify that I attended the deceased from **October 26**, 19**40**, to **October 31**, 19**40**, that I last saw her alive on **October 31**, 19**40** and that death occurred on the date and hour stated above.

Immediate cause of death **Right Cerebral Hemorrhage with Left Hemiplegia** **5d**
Due to **Essential Hypertension** **5yrs.**
Due to **Generalized Atherosclerosis** **10yrs.**

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____
Of autopsy _____

Duration
5d
5d
5yrs.
10yrs.
PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature **Samuel Walker** (M. D. _____)
Address **1515 Lafayette Avenue** Date signed **10/31/40**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed John Ketter
Licensed Embalmer No. 3880
P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.